Congressional Research Service

Memorandum February 12, 2007

SUBJECT: **Summary of Testimony to the House Energy and Commerce Health Subcommittee**

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The latest estimates from 2005 indicate that there are 47 million uninsured people in the United States, 9 million of whom are children (under age 19). More than half of uninsured children were in a two-parent family, and 60% of uninsured children were in a family where a parent worked full-time for the entire year.

Between 1996 and 2005, the percentage of children who were uninsured has fallen significantly. Although private coverage of children declined over this period (significantly for all children and for Hispanic children, though not for non-Hispanic white or black children), increases in public coverage more than offset the declines in private coverage.

The simultaneous decline in private health insurance and increase in public health insurance over the period raises questions about the extent to which expanded public coverage led to an erosion of private coverage, particularly as eligibility was extended up the income scale through the State Children's Health Insurance Program. However, researchers' estimates of "crowd-out" vary widely, depending on the analytic assumptions made. A congressionally mandated study found that 28% of recent SCHIP enrollees had private health insurance at some point during the six months before enrolling in SCHIP. One-half of these enrollees (14% of the total) lost that private coverage involuntarily during that period. Other estimates are provided or referred to in the written testimony.

Health insurance as a bill-paying mechanism by itself is not enough to guarantee high-quality care for children. An important determinant for children's health is whether they have access to a regular health care provider (for example, a physician who knows the child's health care needs). For this reason, experts say it is critical that uninsured children who are eligible for coverage (whether private or public) enroll in that coverage, since insured children are much more likely to have a regular health care provider, and therefore have better health outcomes, than uninsured children.

Researchers estimate among uninsured children, 62% to 75% are eligible for public coverage and 42% have employer-sponsored health insurance available to them, generally through a parent's employer. Children who are eligible for coverage may not be enrolled for a variety of reasons, including perceived obstacles to enrollment or lack of a strong interest in health insurance. Options to enroll eligible but insured children could include outreach and education efforts as well as mandates with financial penalties for uninsurance.

Children's Source of Health Insurance: Testimony Before the House Energy and Commerce Health Subcommittee

February 14, 2007

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Chairman Pallone, Mr. Deal, and other members of the Subcommittee, my name is Chris Peterson, and I am a Specialist in Social Legislation with the Congressional Research Service (CRS). Thank you for the opportunity to testify about the characteristics of children in the U.S. without health insurance.

I would like to begin by describing current estimates of children's health insurance coverage and how they have changed in the past 10 years. Over that period, private health insurance among children has declined, but public coverage has increased — in fact, more than offsetting the declines in private health insurance. I will present some estimates on the extent to which the declines in private health insurance are related to public health insurance expansions. I will also point to research that shows, particularly for children, that health insurance is beneficial not only because it provides financial coverage but also because it can help to establish a usual source of care for children — something that is considered critical for children's health outcomes. Despite these potential benefits, millions of uninsured children who are eligible for public and/or private coverage remain uninsured. I conclude with some of the reasons why this might be the case and what options might be available to address this.

Estimates of Children's Health Insurance Coverage

The latest estimates from 2005 indicate that there are 47 million uninsured people in the United States, 9 million of whom are children (under age 19).[1] More than half of uninsured children were in a two-parent family, and 60% of uninsured children were in a

[1]CRS Report 96-891, "Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2005," by Chris L. Peterson, August 30, 2006, based on Current Population Survey data.

family where a parent worked full-time for the entire year (**Figure 1** at the end of the written testimony) .

Table 1. Health Insurance Coverage of Children (Under Age 18), 1996 and 2005

All children (<18)			
	1996	2005	Percentage-point Change
Private	63%	58%	-5
Public	21%	31%	+10
Uninsured	16%	11%	-5
Non-Hispanic white children			
	1996	2005	Percentage-point Change
Private	74%	72%	-2
Public	14%	21%	+7
Uninsured	13%	8%	-5
Non-Hispanic black children			
	1996	2005	Percentage-point Change
Private	42%	41%	-1
Public	41%	50%	+9
Uninsured	18%	11%	-6
Hispanic children			
	1996	2005	Percentage-point Change
Private	39%	31%	-9
Public	33%	48%	+16
Uninsured	28%	20%	-8

Source: Jeffrey A. Rhoades, "Health Insurance Status of Children in America, First Half 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #131, June 2006. Jessica P. Vistnes and Jeffrey A. Rhoades, "Changes in Children's Health Insurance Status, 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #141, September 2006.

Between 1996 and 2005, the percentage of children who are uninsured has fallen from 16% to 11% (**Table 1**). This 5 percentage point drop occurred in spite of the fact that employer-sponsored coverage rates among children also fell by 5 percentage points

(from 63% in 1996 to 58% in 2005). This overall decline in the uninsured is due to an increase in the prevalence of public health insurance (from 21% of children covered in 1996 to 31% in 2005).[2]

The changes in children's sources of health insurance vary dramatically by race/ethnicity. For example, among (non-Hispanic) white and black children, private coverage did not change significantly between 1996 and 2005. However, significant increases in public health insurance among white and black children significantly reduced their rate of uninsurance. Among Hispanics, the decline in private coverage was large between 1996 and 2005. However, because the increases in public coverage were even larger, the percentage of uninsured Hispanic children also dropped.[3]

A decade ago, in 36% of married working families (with children) without an employer offer of health insurance, all family members were uninsured. That percentage dropped to 23% by 2005, and families with partial coverage (some family members without health insurance, some with) rose from 29% in 1997 to 40% in 2005, according to new research by the Agency for Healthcare Research and Quality (AHRQ). The same trend is true among *single*-parent working families without an employer offer. In 1997, 24% of these families had the entire family uninsured. The percentage has dropped to 17%, with partial coverage rising from 32% in 1997 to 41% in 2005.[4]

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[2] Jeffrey A. Rhoades, "Health Insurance Status of Children in America, First Half 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #131, June 2006.

[3] Jessica P. Vistnes and Jeffrey A. Rhoades, "Changes in Children's Health Insurance Status, 1996–2005: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 18," Agency for Healthcare Research and Quality Statistical Brief #141, September 2006.

[4] Jessica P. Vistnes and Barbara Schone,"Pathways to Health Insurance Coverage: The Changing Role of Public and Private Sources," working paper, 2007.

Estimates of the Relationship Between Declining Private Coverage and Increasing Public Coverage

The State Children's Health Insurance Program (SCHIP), which was created by the Balanced Budget Act of 1997 (BBA 97), receives much of the credit for the increases in public coverage among children over the past decade. Before SCHIP, the states' most common upper-income eligibility level for children 1 to 5 years old was 133% of poverty through Medicaid. For 15-year-olds, states' most common upper-income eligibility level for public coverage was 100% of poverty.[5] Now, the most common upper-income eligibility level for states' public coverage of children of all ages is 200% of poverty through SCHIP (approximately $35,000 for a family of three).

One of the questions this raises — and one that was raised as SCHIP was being developed a decade ago — is the extent to which expanded public coverage might lead to an erosion of private coverage, particularly as eligibility is extended up the income scale. Even today, researchers produce SCHIP-related estimates of "crowd-out" that vary widely and are highly dependent on the analytic assumptions made.[6]

Congress mandated an evaluation to look into this issue, among others. The evaluation found that 28% of recent SCHIP enrollees had private health insurance at some point during the six months before enrolling in SCHIP. One-half of these enrollees

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[5]Thomas Buchmueller et al., "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry*, volume 42, number 3, Fall 2005, p. 220.

[6] See analysis of the literature in Table 1 of Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research Working Paper 12858.

(14% of the total) lost that private coverage involuntarily during that period.[7] The study also examined what percentage of Medicaid and SCHIP child enrollees had parents with employer-sponsored insurance for which the employer paid some or all of the premium. In California, for example, 10% of Medicaid-enrolled children had a parent in such an employer plan, compared to 40% of SCHIP-enrolled children.[8] It is unclear whether, in the absence of public coverage, these children would have been enrolled in private coverage or would have been uninsured.

The research by AHRQ mentioned earlier also looked at changes in coverage among working families (with children) with an offer of employer-sponsored health insurance. Among working *married* families with an offer of employer-sponsored coverage, virtually none had parents enrolled in private coverage with their children in public coverage in 1997. The current percentage is still a relatively small 1.5%. Among working *single*-parent families with children where there was an offer of employer-sponsored coverage, the percentage of families where the adults have private coverage and the children have public coverage rose from 5% in 1997 to 16% in 2005. Again, without additional analysis, one cannot say, in the absence of public coverage, whether these children would have been enrolled in private coverage or would have been uninsured.[9]

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[7] "Congressionally Mandated Evaluation of the State Children's Health Insurance Program," Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. xv.

[8] "Congressionally Mandated Evaluation of the State Children's Health Insurance Program," Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. 31. Not counting in the "substitution estimate" those children with elevated health care needs reduces the estimates to 8% of child Medicaid enrollees and 11% of SCHIP enrollees.

[9] Jessica P. Vistnes and Barbara Schone,"Pathways to Health Insurance Coverage: The Changing Role of Public and Private Sources," working paper, 2007. Researchers at AHRQ have also found that if one accounts for all of the various forms of public spending on uninsured children, privately insured children, and SCHIP, then the net cost of SCHIP is substantially less than one might conclude by simply examining SCHIP budgetary outlays. See Thomas M. Selden and Julie L. Hudson, "How Much Can Really Be Saved

Effects of Health Insurance on Children's Health

Health insurance as a bill-paying mechanism by itself is not enough to guarantee high-quality care. Research has shown that, for children, lacking a regular health care provider (for example, a physician who knows the child's health care needs) has a greater negative effect on primary care quality than not having insurance. In fact, when a child needed care, lack of a regular provider was found to be as detrimental as not receiving care at all.[10] Thus, a key impact of health insurance on children's health is not merely paying the bills but ensuring access to or establishing a relationship with a health care provider.

A comparison of children's access to primary care physicians found similar rates of access among those enrolled in Medicaid, SCHIP and commercial plans,[11] indicating that both public and private health insurance may be effective in this regard (although there are differences depending on the studies and the measures[12]).

By Rolling Back SCHIP?" *Inquiry*, volume 42, Spring 2005, p. 16.

[10] M. Seid and G. D. Stevens, "Access to Care and Children's Primary Care Experiences: Results from a Prospective Cohort Study," *HSR: Health Services Research*, volume 40, number 6, December 2005, pp. 1758–1780.

[11] "State Accomplishments: Access and Quality," Margo Rosenbach, presentation at the National Academy for State Health Policy conference "SCHIP At 10," February 22, 2006. The percentage of 12-24-month-olds with a primary care physician (PCP) visit was 94% in SCHIP, 95% in Medicaid, and 97% in commercial plans. The percentage of 25-month-olds to 6-year-olds with a PCP visit was 87% in SCHIP, 85% in Medicaid, and 89% in commercial plans. The percentage of 7-11-year-olds with a PCP visit was 86% in SCHIP, 83% in Medicaid, and 89% in commercial plans.

[12] See, for example, the review of the literature by insurance type in Aimee E. Jeffrey and Paul W. Newacheck, "Role of Insurance for Children With Special Health Care Needs: A Synthesis of the Evidence," *Pediatrics*, volume 118, number 4, October 2006, p. 1030.

Children Eligible But Not Enrolled in Coverage

Eligibility for public coverage. Researchers estimate that 62% to 75% of uninsured children are eligible for public coverage.[13] Among the parents of low-income uninsured children, nearly half believe their children are eligible.[14] Yet they do not enroll. Among the parents of low-income uninsured children, 84% said they would enroll if told the child is eligible; 16% would not.[15] This suggests a need for outreach that not only informs parents about availability, but also educates them about the benefits of coverage.

Eligibility for private coverage. Tepid responses to offers of health insurance are also observed among those with potential access to private coverage. Research by the California Health Care Foundation found that among higher-income individuals (above 200% of poverty) who were uninsured, only 16% were considered "cost-constrained" — that is, they "attach high importance to having health insurance but say that they would not buy existing products at their current prices. ... (M)ore than one-third have children." Another 26% were considered "prime prospects" — that is, they "place high importance on having health insurance and indicate a willingness to pay amounts that are near — and often substantially above — the actual cost of health insurance premiums. ... More than one-third have children." The remaining 58% of higher-income uninsured individuals (who were less likely to have children than the

[13] Thomas M. Selden et al., "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, volume 23, number 5, September/October 2004, p. 39. Lisa Dubay et al., "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* Web exclusive, November 30, 2006, p. W22.

[14] "Congressionally Mandated Evaluation of the State Children's Health Insurance Program," Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. xx.

[15] "Congressionally Mandated Evaluation of the State Children's Health Insurance Program," Final Report to Congress, Mathematica Policy Research, October 26, 2005, p. xx.

other groups) "indicated that health insurance did not rank high as a spending priority," although many "said they would pay the price when presented with actual health insurance premiums."[16]

According to AHRQ, approximately 42% of uninsured children have employment-sponsored health insurance available to them, generally through a parent's employer. Among uninsured people of all ages, approximately 27% have access to health insurance through an employer.[17] However, recent research has found that workers with a weak interest in health insurance tend to choose jobs that do not offer health insurance, ostensibly in return for higher wages relative to similar jobs that offer health insurance.[18] Thus, the estimates presented in this paragraph may understate uninsured individuals' true access to employer-sponsored health insurance.

Overall, 86.7% of private-sector employees work in a firm that offers health insurance (2004), which is not significantly different than the offer rate in 1996 of 86.5%.[19] However, over the same period, the percentage of employees enrolling in the coverage for which they are eligible has fallen significantly, from 69.5% in 1996 to 62.6% in 2004.[20] This may be because of increasing premiums and cost-sharing for

[16] "To Buy or Not To Buy: A Profile of California's Non-Poor Uninsured," California HealthCare Foundation and the Field Research Corporation, 1999.

[17] Preliminary analyses by Tom Selden of the Agency for Healthcare Research and Quality (AHRQ) in response to CRS request, February 12, 2007.

[18] Alan C. Monheit and Jessica Primoff Vistnes, "Health Insurance Enrollment Decisions: Preferences for Coverage, Worker Sorting, and Insurance Take-Up," National Bureau of Economic Research Working Paper 12429, August 2006.

[19] Agency for Healthcare Research and Quality. Percent of private-sector employees in establishments that offer health insurance by firm size and selected characteristics (Table I.B.2), years 1996-2004: 1996 (Revised March 2000) and 2004 (July 2006). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC [http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp], February 12, 2007. The rates were not significantly different for workers in large firms, comparing 1996 offers rates to 2004 offer rates, or in small firms.

[20] Agency for Healthcare Research and Quality. Percent of private-sector employees that are enrolled in health insurance at establishments that offer health insurance by firm size and selected characteristics (Table I.B.2.b), years 1996-2004: 1996 (Revised March 2000) and 2004 (July 2006). Medical Expenditure

employer-sponsored health insurance. Although employers are paying roughly the same percentage of the premiums they did a decade ago, the growth in total premiums has been well in excess of wage growth or inflation. Moreover, cost-sharing in employer-sponsored plans (for example, deductibles and copayments) has also increased substantially. Not only is the total premium higher for families than for single coverage, but employers generally pay a smaller percentage of the premium for family coverage than for single coverage.[21]

Options to increase enrollment among uninsured children eligible for coverage. Across the income spectrum, there are individuals who are eligible for health coverage (some public, some private) who do not enroll. Some research, especially with respect to children's health, suggests that increasing awareness of health insurance and its impact on health might lead to additional enrollment. Others have suggested making the process of enrollment easier.

In public as well as employer-sponsored coverage, individuals usually receive substantial financial subsidies. Individuals who are eligible and sometimes able to pay for coverage may find themselves taking up that coverage in states that levy financial penalties on individuals who do not enroll in coverage. For example, for tax year 2007, Massachusetts will deny individuals their state income tax exemption(s) — worth up to $189 for a single person or $379 for a couple — if they do not enroll in affordable health

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Panel Survey Insurance Component Tables. Generated using MEPSnet/IC [http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp], February 12, 2007. The rates *were* significantly different for workers in large firms, comparing 1996 take-up rates to 2004 take-up rates, as well as in small firms.

[21] One group of researchers found that in states where SCHIP eligibility was expanded, employers were not more likely to drop coverage but were more likely to charge more for family coverage. Thomas Buchmueller et al., "The Effect of SCHIP Expansions on Health Insurance Decisions by Employers," *Inquiry*, volume 42, number 3, Fall 2005, p. 220.

insurance. Beginning with tax year 2008, an additional penalty will be levied for each month an individual is without insurance, equal to 50% of the lowest premium for which he or she would have qualified.[22] In short, besides the multitude of existing "carrots" to entice people to enroll in health insurance, states are beginning to seriously consider "sticks" as well.

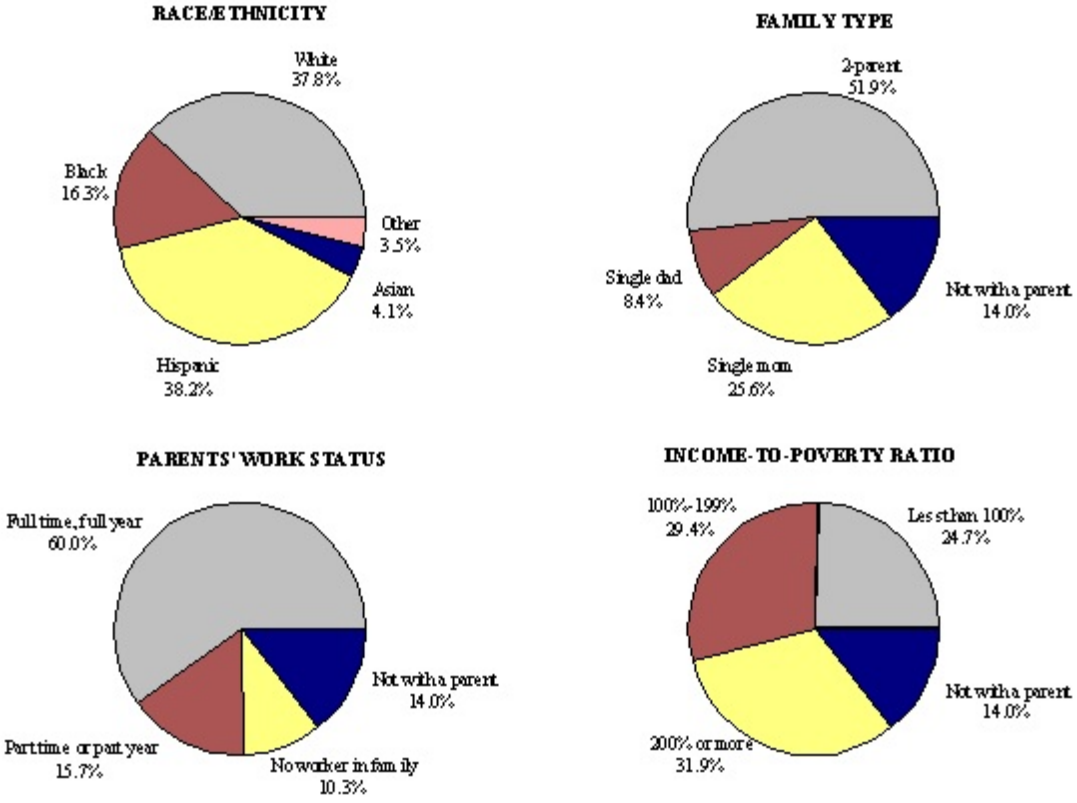
One issue with the future of the Massachusetts health reform, and an issue policymakers deal with nationwide, is defining "affordability." How does one separate the uninsured into (1) those who don't have the means to pay for health insurance, and (2) those who might have the means but don't want to pay? It is a very difficult question to answer — but looking at the situation on the ground, it would seem that the states and the federal government use the federal poverty level as a primary yardstick for determining the appropriate role for providing health insurance.

As I mentioned, the most common upper-income eligibility level for children in SCHIP is 200% of poverty. That is about $35,000 for a family of three. Coverage for parents in public programs is tied to lower income standards than for children. However, even for children, SCHIP's upper-income eligibility levels vary substantially by state – from 140% of poverty in North Dakota to 350% of poverty in New Jersey. That is $24,000 for a family of three in North Dakota and $60,000 for a family of three in New Jersey. Of course, the cost of living varies dramatically across states, and states vary along other dimensions as well. One way Medicaid and SCHIP may address these variations is through existing flexibility to expand eligibility up the income scale.

[22] For additional information, see CRS Report RS22447, "The Massachusetts Health Reform Plan: A Brief Overview," by April Grady, May 26, 2006.

However, because Medicaid and SCHIP are financed mostly by the federal government, the disparate upper-income thresholds raise questions about the collective obligation to pay for various states' higher-income populations and about how to define equitable federal financing among the states. Similar issues also emerge over the role of the states versus the federal government with respect to private health insurance, in terms of what should be required by insurers, individuals and employers with respect to health insurance.

Figure 1. Characteristics of Uninsured Children Under 19, 2005



Source: CRS Report 97-975, "Health Insurance Coverage of Children, 2005," by Chris L. Peterson.